

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 03/13/01, 04/25/01, and 06/11/01?
- b. The request was received on 02/28/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution dated 04/01/02
 - b. HCFA-1500s
 - c. EOBs
 - d. Reimbursement data
 - e. Medical Records
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60
 - b. HCFA-1500s
 - c. Audit summaries/EOB
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/02/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 04/03/02. The only response from the insurance carrier is the 3 day response which was received on 03/01/02. The carrier did not submit a 14 day response.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The amount of reimbursement received is not fair and reasonable.
2. Respondent: The carrier has reimbursed an amount that is fair and reasonable.

IV. FINDINGS

1. Based on Commission Rule 133.307(d)(1&2), the only dates of service eligible for review are 03/13/01, 04/25/01, and 06/11/01.
2. The carrier's EOBs have the denials, "M – REDUCED TO FAIR AND REASONABLE" and "D – REIMBURSEMENT FOR UNILATERAL OR BILATERAL PROCEDURES IS BEING WITHHELD AS THE MAXIMUM NUMBER OF OCCURENCES FOR A SINGLE DATE OF SERVICE OR MAXIMUM LIFETIME FOR THE CLAIM HAS BEEN EXCEEDED."
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
03/13/01 04/25/01 06/11/01	76499-27-22	\$300.00 \$400.00 \$350.00	\$105.60 \$105.60 \$105.60	M M M	DOP DOP DOP	Texas Workers' Compensation Commission Act & Rules, Sec. 413.011(d), Rule 133.304(i)(1-4); MFG, GI (III), CPT & modifier descriptors	Commission Rule 133.304 (i)(1-4) places certain requirements on the carrier when reducing the billed amount to fair and reasonable. It requires the carrier to explain their methodology in determining fair and reasonable. The carrier has not submitted their methodology. The provider has submitted EOBs from other carriers to document fair and reasonable reimbursement and comply with the criteria of Sec. 413.011(d) of the Texas Labor Code. However, the provider has not adequately documented the reasons the billed amount is different for each date of service. The EOBs from other carriers generally indicate a billed amount of \$350.00. These EOBs also indicate that the provider has accepted from \$297.50 to \$350.00 as fair and reasonable reimbursement. Due to the fact there is no MAR, the Medical Review Division must determine from the parties information what represents fair and reasonable reimbursement. The provider has submitted the more persuasive documentation which indicates that \$297.50 is fair and reasonable. Therefore, the provider is entitled to additional reimbursement of \$575.70 (\$297.50 - \$105.60 = \$191.90 x 3 DOS).
03/13/01 04/25/01 06/11/01	76499-27	\$300.00 \$300.00 \$300.00	\$0.00 \$0.00 \$0.00	D D D	DOP DOP DOP	Texas Workers' Compensation Commission Act & Rules, Sec. 413.011(d), Rule 133.304(i)(1-4); MFG, GI (III)(A), CPT & modifier descriptors	The MFG, General Instructions (III)(A) states, "(DOP) in the maximum allowable reimbursement (MAR) column indicates that the value of this service shall be determined by written documentation..." The medical reports, for each date of service in dispute, does not contain sufficient documentation of the billed DOP procedure. Therefore, no reimbursement is recommended.
Totals		\$1950.00	\$316.80				The Requestor is entitled to reimbursement in the amount of \$575.70 .

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$575.70 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 9th day of May 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.